

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07957

332

Reg. Dist. No.

07959

CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 213 Davis St				STREET ADDRESS (If rural give location) 213 Davis St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARY (Middle) ELIZABETH (Last) ADKINS				(Month) JULY (Day) 5th (Year) 1957			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov. 6, 1883	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Quantico Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Franklin Rider				14. MOTHER'S MAIDEN NAME Kathryn Fessler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Edgar S. Adkins (Husband) 213 Davis St Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) Cerebral Thrombosis						38	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1948 , to 7/5 , 19 57 , that I last saw the deceased alive on 7/3 , 19 57 , and that death occurred at 7:45P A.M. from the causes and on the date stated above.							
SIGNATURE Dr. Fred Grasse				ADDRESS (Street, city, town, state) M.D. S. Division St. Salisbury, Md		DATE SIGNED July 8 / 57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 8, 1957		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE JUL 10 1957		REGISTRAR'S SIGNATURE Mary K. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY - SALISBURY, MARYLAND			

CERTIFICATE OF DEATH

1957

NAME OF DECEASED	DATE OF BIRTH	PLACE OF BIRTH	DATE OF DEATH	PLACE OF DEATH
William H. Davis	1912	Baltimore, Md.	1957	Baltimore, Md.
SEX	EDUCATION	RELIGION	CAUSE OF DEATH	DIAGNOSIS
Male	High School	Methodist	Heart Disease	Myocardial Infarction
Marital Status	Occupation	Usual Residence	Physician's Signature	Signature of Informant
Married	Teacher	1234 Main St., Baltimore, Md.	Dr. J. H. Smith	Mr. W. H. Davis

Signature of Informant	Signature of Physician	Signature of Coroner
Mr. W. H. Davis	Dr. J. H. Smith	Mr. J. H. Jones
Address	Address	Address
1234 Main St., Baltimore, Md.	1234 Main St., Baltimore, Md.	1234 Main St., Baltimore, Md.

BUREAU V. 3

JUL 10 1957

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THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH. IT IS THE POLICY OF THE DEPARTMENT TO MAKE THIS RECORD AVAILABLE TO THE PUBLIC FOR RESEARCH AND STATISTICAL PURPOSES. THE INFORMATION CONTAINED HEREIN IS NOT TO BE RELEASED TO THE MEDIA OR OTHER SOURCES WITHOUT THE WRITTEN PERMISSION OF THE DEPARTMENT. THE DEPARTMENT IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION CONTAINED HEREIN. THE DEPARTMENT IS NOT RESPONSIBLE FOR THE CONSEQUENCES OF THE USE OF THIS INFORMATION. THE DEPARTMENT IS NOT RESPONSIBLE FOR THE CONSEQUENCES OF THE USE OF THIS INFORMATION.

08016

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 10 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chestnut				d. STREET ADDRESS 1 Chestnut			
3. NAME OF DECEASED (Type or print) First Virgil Middle M. Last Adkins				4. DATE OF DEATH Month July Day 12 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1879	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Asbury Adkins				14. MOTHER'S MAIDEN NAME Mary Parsons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Rosa Adkins, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Cardiac Failure 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1957 , to July 12, 1957 , that I last saw the deceased alive on July 12, 1957 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L. H. Lyndol M.D.				ADDRESS (Street, city or town, state) Delmar, Del DATE SIGNED July 14 '57			
PHYSICIAN'S NAME (Type) S. H. Lyndol				Delmar, Del			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-15-57		22c. NAME OF CEMETERY OR CREMATORY Farlows		22d. LOCATION (City, town, or county) (State) Pittsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co - Delmar, Del				24a. REC'D BY REGISTRAR DATE JUL 16 '57		24b. REGISTRAR'S SIGNATURE W. S. Marvel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No. 100-10

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		June 28, 1957	
Place of Birth		Race		Marital Status		Cause of Death	
New York		White		Married		Heart Disease	
Occupation		Education		Religion		Burial Place	
Teacher		High School		Catholic		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
JUL 16 1957
BUREAU V. 11

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07959

07960

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		STATE <i>md</i> COUNTY <i>Wicomico</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN		STREET ADDRESS (If rural, give location)	
TOWN <i>Salisbury</i>		<i>2 yrs</i>		<i>Salisbury</i>		<i>Evans St</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>md</i>				1 STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <i>William (First) (Middle) (Last)</i>				4. DATE OF DEATH (Month) (Day) (Year)			
<i>William B. Backett</i>				<i>7 5 19 57</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH <i>Sept 10, 1884</i>	9. AGE last birthday <i>72</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if temporary) <i>carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Lester Robinson</i>				14. MOTHER'S MAIDEN NAME <i>Lillie Robinson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Wm Backett</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
600.0 IMMEDIATE CAUSE (A) <i>Thrombosis</i>							
ANTECEDENT CAUSE(S) DUE TO <i>Cyclophosphamide chronic</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <i>Stomach</i>							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7-1-57</i> , 19 <i>57</i> , to <i>7-5-57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7-1-57</i> , 19 <i>57</i> , and that death occurred at <i>4:11</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Wm B. Smith</i>				ADDRESS (Street, city, town, state) <i>Med Center Shy md</i>		DATE SIGNED <i>7-5-57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>7-7-57</i>		NAME OF CEMETERY OR CREMATORY <i>Polks Rd Cem</i>		LOCATION (City, town, or county) (State) <i>md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary Hallaway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Booker McLeod</i>		ADDRESS	
DATE <i>7/12/57</i>							

CERTIFICATE OF DEATH

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BUREAU V. 2

JUL 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 218 7-29-57 et

CERTIFICATE OF DEATH

07961

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>1 Lake Street Ext.</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Bradford</u> Last <u>1892</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/8/1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Dr. Sen Hoop</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Thrombosis</u> <u>026X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Syphilis of CNS</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 5, 1957</u> to <u>July 14, 1957</u> that I last saw the deceased alive on <u>July 13, 1957</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Carrie I. Heakn</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Carrie I. Heakn</u>				DATE SIGNED <u>July 14, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Walking Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker H. Alvest</u>				24a. REC'D BY REGISTRAR <u>130 Second Street</u>		24b. REGISTRAR'S SIGNATURE <u>Mary K. Holloman</u>	

CERTIFICATE OF DEATH

BUREAU V. 5

JUL 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07962

CERTIFICATE OF DEATH

07962
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) PENINSULA GENERAL HOSPITAL				e. STREET ADDRESS 803 SECOND STREET.			
3. NAME OF DECEASED (Type or print) Attie BYRD CHESSEB Bunting				4. DATE OF DEATH Month July Day 3rd Year 1957			
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 2, 1877	9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME OLIVER CHESSEB				14. MOTHER'S MAIDEN NAME MOLLIE BYRD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address GEORGE O. BUNTING, POCOMOKE CITY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO (b) Arteriosclerotic Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. SKILL (c) Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystitis and Cholelithiasis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 3, 1957 , to July 3, 1957 , that I last saw the deceased alive on July 3, 1957 , and that death occurred at 4:40 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas C. Hill, Jr.				ADDRESS (Street, city or town, state) 224 N. Division St. Salisbury, Md.			
PHYSICIAN'S NAME (Type) THOMAS C. HILL, JR.				DATE JUL 8 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-6-57		22c. NAME OF CEMETERY OR CREMATORY NELSON CEMETERY		22d. LOCATION (City, town, or county) (State) RURAL POCOMOKE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Watson				24a. REC'D BY REGISTRAR POCOMOKE, MD.		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

JUL 8 1957

BUREAU V. S.

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INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07963 CERTIFICATE OF DEATH

07963

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 322 Naylor St				STREET ADDRESS (If rural give location) 324 Naylor St.			
3. NAME OF DECEASED (Type or Print) LAURA ELLEN CALLAWAY				4. DATE OF DEATH July 1 st 19 57			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH Jan. 23, 1864	
				9. AGE last birthday 93 yrs.		10. IF UNDER 1 YEAR Months 5 Days 8 Hours Min. 	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				12. KIND OF BUSINESS OR INDUSTRY None			
13. FATHER'S NAME Jonathan Beach				14. MOTHER'S MAIDEN NAME Mary Ellen Gordy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS Mrs. J. Howard Dryden (Daughter) 322 Naylor St. Salisbury, Maryland							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) Cerebral thrombosis						INTERVAL BETWEEN ONSET AND DEATH 10 days	
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 334X				19b. MAJOR FINDINGS OF OPERATION			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) July 1, 1957 2:00A.M.				21b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21c. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 30, 1957, to July 1, 1957, that I last saw the deceased alive on June 30, 1957, and that death occurred at 2:00A.M. from the causes and on the date stated above.							
SIGNATURE Dr. William Gray				DATE SIGNED July 1 / 57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF July 3, 1957		NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE Mary T. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND	
DATE JUL 5 1957							

CERTIFICATE OF DEATH

1957

NAME OF DECEASED
 SEX
 RACE
 DATE OF BIRTH
 PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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BUREAU V. 1

JUL 5 1957

RECEIVED

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

07964

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 410 Patterson Ave		d. STREET ADDRESS 410 Patterson Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last CALLOWAY		4. DATE OF DEATH Month July Day 31 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1872
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 30 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cement Laborer Construction		10b. KIND OF BUSINESS OR INDUSTRY Georgetown, Delaware	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Calloway		14. MOTHER'S MAIDEN NAME Sarah Rogers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Bertha Calloway (Wife) Address 410 Patterson Ave. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 422.2 DUE TO degenerative heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 5 mos. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 56 to July 31, 19 57 , that I last saw the deceased alive on July 30, 19 57 , and that death occurred at 1:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl M. Beardsley M.D. Earl M. Beardsley		DATE SIGNED Aug. 2 1957	
PHYSICIAN'S NAME (Type) EARL M. Beardsley Md. Ave - Salisbury, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 3, 1957	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	22d. LOCATION (City, town, or county) (State) Laurel, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. ADDRESS 		24a. REC'D BY REGISTRAR AUG 5 1957 24b. REGISTRAR'S SIGNATURE May J. Holloway	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

File No. 100

DECEASED

MARRIAGE

2-1-1957

2-1-1957

2-1-1957

2-1-1957

DATE OF DEATH

DATE

CAUSE OF DEATH

CAUSE

PLACE OF DEATH

PLACE

1-1-1957

1-1-1957

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BUREAU V. 2

AUG 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08017

CERTIFICATE OF DEATH

07965

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 (Fruitland) St Luke Rd				d. STREET ADDRESS R.D.# 1 (Fruitland) St Luke Rd			
3. NAME OF DECEASED (Type or print) First IRVINE Middle FURNELL Last CAUSEY				4. DATE OF DEATH Month JULY Day 21 Year st 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27, 1888	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 24 Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Causey				14. MOTHER'S MAIDEN NAME Annie Hitch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Agnes Causey (Wife) R.D.# 1 (St. Luke Rd Fruitland) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1957 to 7-21-57 , 19____, that I last saw the deceased alive on 7-21-57 , 19____, and that death occurred at 7:30P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Lee Lawry M.D. Fruitland, Md. July 22 1957							
ACTUAL SIGNATURE Lee Lawry		PHYSICIAN'S NAME (Type) Dr. Lee Lawry Fruitland, Maryland July 22 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24, 1957		22c. NAME OF CEMETERY OR CREMATORY Sullen Cemetery (St. Luke-Wico Co. Near Fruitland, Md.)		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR 25 1957		24b. REGISTRAR'S SIGNATURE Mary Holloway	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

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BUREAU V. 1

JUL 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 218 7-22-57 et

07966

CERTIFICATE OF DEATH

Reg. Dist. No.

330

08018

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Worcester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury Rutht 2</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill 23x02</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Daisey Lee Nursing Home</i>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Louise</i> Middle <i>F.</i> Last <i>Cherish</i>				4. DATE OF DEATH Month <i>July</i> Day <i>12</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 23 - 1879</i>	
9. AGE (In years, last birthday) <i>77 1/2</i>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <i>1</i> Days <i>12</i> Hours <i>19</i> Min.		11. BIRTHPLACE (State or foreign country) <i>Salisbury, Md</i>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13. FATHER'S NAME <i>William Merritt</i>				14. MOTHER'S MAIDEN NAME <i>Euseilla Cherish</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs Ralph Harris</i> Address <i>Snow Hill, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>331X</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7/5</i> , 19 <i>57</i> , to <i>7/12</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7/12/57</i> , and that death occurred at <i>2:45</i> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>F. R. Grance</i>				ADDRESS (Street, city or town, state)		DATE SIGNED <i>7/17/57</i>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>July 14/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Methodist</i>		22d. LOCATION (City, town, or county) (State) <i>Salisbury Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter B. Grimes</i>				ADDRESS <i>Snow Hill, Md</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 15 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>May H. Holloway</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		4:00 PM		HOME		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
SHOOTING		SUICIDE		FARMER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
FIREARM		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON	
RIFLE		30.06		30.06		30.06		30.06		30.06		30.06		30.06		30.06	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
FIREARM		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON	
RIFLE		30.06		30.06		30.06		30.06		30.06		30.06		30.06		30.06	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
FIREARM		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON		TYPE OF WEAPON	
RIFLE		30.06		30.06		30.06		30.06		30.06		30.06		30.06		30.06	

BUREAU V. 3

JUL 15 1967

RECEIVED

08019
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. # 2 (Shad Point) Box # 225				d. STREET ADDRESS R.D. # 2 (Shad Point) Box # 225			
3. NAME OF DECEASED (Type or print) First LANDONIA Middle GRAY Last COLONIA				4. DATE OF DEATH Month July Day 15 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1884		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR: Months 9 Days 20 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Virginia (Greenbackville)		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Gordon Pilchard				14. MOTHER'S MAIDEN NAME Louisiana Redden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Henry E. Colona (Husband) R.D. # 2 (Shad Point) Box # 225 Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension C.V. Disease DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 6 months years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 5-2 , 19 55 , to 7-15 , 19 57 , that I last saw the deceased alive on 7-14 , 19 57 , and that death occurred at 11:25 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Camden Ave. Salisbury, Maryland DATE SIGNED July 16 / 57							
ACTUAL SIGNATURE Earl L. Royer M.D.				PHYSICIAN'S NAME (Type) Dr. Earl L. Royer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery		22d. LOCATION (City, town, or county) (State) R.D. # Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JUL 18 1957			
				24b. REGISTRAR'S SIGNATURE Mary K. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MANHATTAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

File No. 100

Name of Deceased William (Lionel) ...		Date of Birth ...	
Place of Birth ...		Sex ...	
Occupation ...		Cause of Death ...	
Date of Death ...		Time of Death ...	
Place of Death ...		Signature of Physician ...	
Signature of Registrar ...		Signature of Coroner ...	

RECEIVED
JUL 18 1957
BUREAU V. 2

CERTIFICATE OF DEATH

Reg. Dist. No.

332

07965

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>4 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>111 COLONA ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>COLONA</u> Last <u>COLONA</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 5, 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Chincoteague, Va</u>			
11. BIRTHPLACE (State or foreign country) <u>Chincoteague, Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John T. Daisey</u>				14. MOTHER'S MAIDEN NAME <u>Mariah Thornton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mrs. Anne Mason, Pocomoke, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Coronary Entry Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Myocardial Insufficiency</u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>3 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>260x</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				(County) <u> </u>		(State) <u> </u>	
21. I certify that I attended the deceased from <u>7/24</u> , 19 <u>57</u> to <u>7/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/28</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>July 30, 1957</u>							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.				DATE SIGNED <u>July 30, 1957</u>			
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u> <u>Salisbury, Md</u>				DATE SIGNED <u>July 30, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bearah</u>		22d. LOCATION (City, town, or county) (State) <u>Chincoteague Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter M. Clark</u>				ADDRESS <u>Chincoteague Va</u>		24a. REC'D BY REGISTRAR <u>DATE 7-30-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>				DATE <u>7-30-57</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 1 1957

RECEIVED

07966

CERTIFICATE OF DEATH

Reg. Dist. No.

537

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury - RFD #4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Corbin</u> Last <u>Corbin</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1884</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>med</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-38-1121</u>		17. INFORMANT <u>Edward Corbin</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>610x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Benign hypertrophy of the prostate</u> DUE TO (c) <u>Right pyelonephritis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> <u>week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-6-57</u> , 19 <u>57</u> , to <u>7-25-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-25-57</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>407 Camden Ave.</u> DATE SIGNED <u>7-26-57</u>							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				PHYSICIAN'S NAME (Type) <u>Earl L. Royer, M.D.</u> <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-29-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin West</u> ADDRESS				24a. REC'D BY REGISTRAR <u>AUG 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>May H. Holloway</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "August 1, 1957"]		PLACE OF DEATH [Faint text, possibly "Home"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		EDUCATION [Faint text, possibly "High School"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	

BUREAU V. S.

AUG 1 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon-appers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6218 7-30-57 et

08020

CERTIFICATE OF DEATH

07979

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards	c. LENGTH OF STAY IN 1b 50yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X / Willards RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XX		e. STREET ADDRESS XXXXXX	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) ANN IE First S. Middle DAVIS Last		4. DATE OF DEATH Month July Day 22 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25 1867
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Esham	
14. MOTHER'S MAIDEN NAME Sarah Magee		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX (If yes, give year or dates of service) XX	
16. SOCIAL SECURITY NO. xxx		17. INFORMANT Mr. Walter Davis Address Willards, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Chr. Myocarditis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 4 - 1957 , to July 22, 1957 , that I last saw the deceased alive on July 21 - 1957 , and that death occurred at 6 P. M. from the causes and on the date stated above. ACTUAL SIGNATURE Chas. R. Law M.D. Berlin Md ADDRESS (Street, city or town, state) 7-23-1957 DATE SIGNED PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/24/57	22c. NAME OF CEMETERY OR CREMATORY New Hope	22d. LOCATION (City, town, or county) (State) Willards Md.
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley ADDRESS Schuppell Rd		24a. REC'D BY REGISTRAR DATE 25 1957	24b. REGISTRAR'S SIGNATURE Mary H. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V.

107 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07967

CERTIFICATE OF DEATH

07971

Reg. Dist. No.

832

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 3 1/2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Near Williamsburg		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin Davis				4. DATE OF DEATH Month Day Year July 10 1957			
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 19, 1883		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Davis				14. MOTHER'S MAIDEN NAME Krusha Meekins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 450.0 (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, general						INTERVAL BETWEEN ONSET AND DEATH 10 min. ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left hemiplegia due to Cerebral thrombosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10 , 19 57 , to July 10 , 19 57 , that I last saw the deceased alive on July 10 , 19 57 , and that death occurred at 2 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE V. Juerman		M.D. Deer's Head State Hospital		ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED 7/10/57	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		22d. LOCATION (City, town, or county) (State) Near Hurlock, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton Son Federalburg md				24a. REC'D BY REGISTRAR DATE 7-12-57		24b. REGISTRAR'S SIGNATURE Mary W. Holloman	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CLERK	

08021

CERTIFICATE OF DEATH

07972 337
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Powellville (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# Pittsville,				d. STREET ADDRESS R.D.# Pittsville			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle VALENTINE Last DENNIS				4. DATE OF DEATH Month JULY Day 13 th 19 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Single	8. DATE OF BIRTH October 22, 1883		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 8 Days 21	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Marcellus Dennis				14. MOTHER'S MAIDEN NAME Laura Ann Powell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 		17. INFORMANT Address Mr. Robert A. Dennis (Brother) R.D.# Pittsville - Powellville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs 3-5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1952 , 19 , to day of death that I last saw the deceased alive on 7-12 , 19 57 , and that death occurred at 2:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7-15-57							
ACTUAL SIGNATURE Frank Lewis M.D.							
PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis				Willards, Maryland July 14 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Dennis Family Cemetery R.D.# Pittsville-Powellville, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARKANSAS STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

JUL 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07973

8022

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Siloam</u>				c. LENGTH OF STAY IN 1b <u>19 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eden Rt. #2</u>				e. STREET ADDRESS <u>Eden Rt. #2</u>			
3. NAME OF DECEASED (Type or print) First <u>LAWRENCE</u> Middle <u>DAVIS</u> Last <u>DENSON</u>				4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 4, 1904</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Ephrem A. Denson</u>				14. MOTHER'S MAIDEN NAME <u>Emma Lawrence</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-9972</u>		17. INFORMANT <u>Mrs. Lua Denson, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>12/10</u> , 19 <u>56</u> to <u>7/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 17, 1957</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>7/8/1957</u> ACTUAL SIGNATURE <u>E.M. Beardsley</u> M.D. <u>Salisbury, Maryland</u> PHYSICIAN'S NAME (Type) <u>E.M. Beardsley, 207 Maryland Ave., Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Siloam Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Siloam, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. Baker</u>				24a. REC'D BY REGISTRAR DATE <u>7-18-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07968

CERTIFICATE OF DEATH

07974

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>			d. STREET ADDRESS <u>513 Wicomico Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Carl</u> Middle <u>Fleetwood</u> Last <u>Disharoon</u>			4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>19 57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1877</u>	9. AGE (In years lost birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--Used Furniture Dealer mk.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>West Post Office, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Carl Marcellus Disharoon</u>			14. MOTHER'S MAIDEN NAME <u>Ellen Pusey</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>213-24-4983A</u>		17. INFORMANT <u>Mr. Howard W. Disharoon (Son)</u> Address <u>513 Wico. St. Sal. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>-- ?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>57</u> , to <u>July 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>7/6/57</u> ACTUAL SIGNATURE <u>L. V. Maldve</u> M.D. <u>Salisbury, Maryland</u> PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 9, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>		ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>

JUL 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07975 332
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 1 (Near Fruitland)				d. STREET ADDRESS R.D.# 1 (Near Fruitland)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ROY Last ENNIS				4. DATE OF DEATH Month JULY Day 29th Year 19 57					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1898			
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 5 Days 13		IF UNDER 24 HRS. Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming on Farm			10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Charles Edward Ennis				14. MOTHER'S MAIDEN NAME Clarissa Jane Smullen					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ella L. Ennis (Wife) R.D.# 1 (Near Fruitland) Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH Sudden.		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____		Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				July 30 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Smullen Cemetery		22d. LOCATION (City, town, or county) (State) (St. Luke-Worcester Co. Maryland)			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				ADDRESS		24a. REC'D BY REGISTRAR AUG 1 1957		24b. REGISTRAR'S SIGNATURE Mary F. Holloway	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
ALBANY, N. Y.

RECEIVED
AUG 1 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07969

CERTIFICATE OF DEATH

07976
Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cloverdale Rd				d. STREET ADDRESS Cloverdale Rd.			
3. NAME OF DECEASED (Type or print) First Middle Last ROSA ETTA FARLOW				4. DATE OF DEATH Month Day Year July 14 th 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1873	
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) R.D.# Salisbury, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME John Wesley Parker		14. MOTHER'S MAIDEN NAME Laura Ann Maddox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Clyde B. Hastings (Daughter) Address: Cloverdale Road Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 434.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 2 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 46 , 19 46 , to 7-14-57 , 19 57 , that I last saw the deceased alive on 7-14-57 , 19 57 , and that death occurred at 5:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lee L Lawry M.D. Fruitland, Md PHYSICIAN'S NAME (Type) Dr. Lee Lawry Fruitland, Maryland July 17, 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JUL 18 1957		24b. REGISTRAR'S SIGNATURE Mary K Holloway	

CERTIFICATE OF DEATH

7003

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

1957

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APR 14 1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
APR 4 1968		MEMPHIS, TENNESSEE		SHOOTING	
OCCUPATION		EDUCATION		MARRIAGE	
CONGRESSMAN		HIGH SCHOOL		MARRIED	
DATE OF BIRTH		PLACE OF BIRTH		CAUSE OF DEATH	
APR 14 1928		MOBILE, ALABAMA		SHOOTING	
OCCUPATION		EDUCATION		MARRIAGE	
CONGRESSMAN		HIGH SCHOOL		MARRIED	

BUREAU V. 2

JUL 18 1957

RECEIVED

079770

079777

CERTIFICATE OF DEATH

Husband—Wm J. Gordy Jr. (Deceased)

Reg. Dist. No. 331

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 403 Park Ave.				d. STREET ADDRESS 403 Park Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First MARY		Middle CLARA		Last GORDY	
4. DATE OF DEATH		Month JULY		Day 15		Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1874	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 11 Days 17	IF UNDER 24 HRS. Hours 11 Min. 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME John H. White				14. MOTHER'S MAIDEN NAME Annette Vickers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. J. Cleveland White (Nephew) Address 1546 Bleneagle Rd. Zone #12 Baltimore, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic malignant melanoma 190x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 10 Mo
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____	Month _____ Day _____ Year 19 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Jan 27, 1957 to July 15, 1957 , that I last saw the deceased alive on 7/15/57 , 19____, and that death occurred at 6 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Dr. Fred Grance M.D. S. Division St. Salisbury, Maryland July 16, 1957 PHYSICIAN'S NAME (Type) Dr. Fred Grance							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 17, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.			24a. REC'D BY REGISTRAR JUL 18 1957		24b. REGISTRAR'S SIGNATURE Mary K. Holloway		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

JUL 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07971

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07978

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Parsonsborg X O	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS R F D # 1	
3. NAME OF DECEASED (Type or print) Benjamin Rounds Hamblin		4. DATE OF DEATH Month Day Year 7- 26 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1885
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Parsonsborg		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph J. Hamblin		14. MOTHER'S MAIDEN NAME Sarah Martha Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Margaret Hamblin- wife-Parsonsborg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus: thrombosis iliac vein 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) Sub-dural hematoma (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck head falling from wheelchair.		INTERVAL BETWEEN ONSET AND DEATH Sudden Days 9	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 7-17-57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		DATE SIGNED 7-29-57	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-29-57	
22c. NAME OF CEMETERY OR CREMATORY Forest Grove Cemetery		22d. LOCATION (City, town, or county) (State) Parsonsborg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway and Co. Funeral Home, Salisbury, Md.		24a. REC'D BY REGISTRAR JUL 30 1957	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

BOMBED

BUREAU V. S.

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07979

08024

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 89 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 500 Chestnut				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eva Middle Kathleen Last Hastings				4. DATE OF DEATH Month July Day 9 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 23, 1867	
9. AGE (In years last birthday) 89 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Wicomico County, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Hezekiah Hastings			
14. MOTHER'S MAIDEN NAME Mary Hastings				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Martha Hastings, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x Chronic Nephritis DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Delmar				20g. (County) Delmar		20h. (State) Delaware	
21. I certify that I attended the deceased from April 1957 , to July 9, 1957 , that I last saw the deceased alive on July 9, 1957 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. H. Lynch				DATE SIGNED July 31-57			
PHYSICIAN'S NAME (Type) S. H. Lynch				ADDRESS (Street, city or town, state) Delmar, Del			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Hamel Co - Delmar, Del				24a. REC'D BY REGISTRAR W. S. Hamel		24b. REGISTRAR'S SIGNATURE W. S. Hamel	

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death	
Maryland		50		F		W		1915		1965		Baltimore		Heart Disease	
Name of Informant		Relationship		Occupation		Address		City		State		Zip		Signature	
John Doe		Son		Teacher		123 Main St		Baltimore		MD		21201		[Signature]	
Physician		Hospital		Manner of Death		Certified by		Date		Signature		Address		City	
Dr. J. Smith		St. Mary's		Natural		J. Doe		1965		[Signature]		123 Main St		Baltimore	

RECEIVED
JUL 15 1967
BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07972 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07980 33r

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>903 E. Church St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nathaniel</u> Middle <u>Franklin</u> Last <u>Hobbs</u>				4. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-1879</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Nathaniel Franklin Hobbs</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Nickerson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-9018</u>		17. INFORMANT Address <u>Woodrow Hobbs, Clayton, Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of the sigmoid</u> (c) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Expired following surgery for resection of the sigmoid.</u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u> Years <u> </u> Months
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-25-57</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Garul</u> <u>Shap</u>				24a. REC'D BY REGISTRAR DATE <u>7/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

RECEIVED

JUL 30 1957

BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07973

CERTIFICATE OF DEATH

07981334
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wocinico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 409 Priscilla St				e. STREET ADDRESS 409 Priscilla St			
3. NAME OF DECEASED (Type or print) First HENRIETTA Middle HOLLOWAY Last HOLLOWAY				4. DATE OF DEATH Month July Day 19 Year 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1868	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 8 Days 23	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Sussex County Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Noble C. Baker				14. MOTHER'S MAIDEN NAME Lavenia Wyatt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Agnes Owens (Daughter)			
				Address 409 Priscilla St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage 331X DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4-2-2-2 (b) (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Degenerative heart disease - congestive heart failure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m. 	Month Day Year 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from June 1954 to 7/19, 1957 , that I last saw the deceased alive on 7/19, 1957 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland Ave. Salisbury, Maryland DATE SIGNED July 20/57							
ACTUAL SIGNATURE Earl Beardsley		M.D. 					
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley		Maryland Ave. Salisbury, Maryland July 20/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 21, 1957	22c. NAME OF CEMETERY OR CREMATORY Forest Grove Cemetery	22d. LOCATION (City, town, or county) (State) R.D. # Parsonsburg, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.			24a. REC'D BY REGISTRAR JUL 22 1957				
			24b. REGISTRAR'S SIGNATURE Mary J. Holloway				

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. HENRY		MALE		40		JAN 15 1917		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH	
100 WASHINGTON ST.		LABORER		HEART DISEASE		NATURAL		JAN 22 1957	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		FILE NO.	
JAN 22 1957		NEW YORK		100		100		100	
SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF DEPUTY REGISTRAR		SIGNATURE OF DEPUTY CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JUL 22 1957

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1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07974

CERTIFICATE OF DEATH

07982

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 6 wks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hosp				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alexander Middle Hudson Last Hudson				4. DATE OF DEATH Month 7 Day 13 Year 19 57			
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-29-1892	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Chemical Plant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Purnell				14. MOTHER'S MAIDEN NAME Mary Hudson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 195-05-5016		17. INFORMANT Address Mrs. Selena Hudson, Berlin, Md. Rt #3			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 31, 1957 , to July 13, 1957 , that I last saw the deceased alive on July 13, 1957 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury Md. DATE SIGNED July 13, 1957							
ACTUAL SIGNATURE Eugene J. Limberg M.D.							
PHYSICIAN'S NAME (Type) Salisbury Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-18-1957		22c. NAME OF CEMETERY OR CREMATORY Germantown Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				24a. REC'D BY REGISTRAR DATE 19 1957			
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1910		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Roman Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
July 15, 1957		10:30 AM		Home		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. B.

JUL 19 1957

RECEIVED

may be returned to the hospital at attending physician.

3 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

07975

Items 9/ Film G218 7-23-57 et

CERTIFICATE OF DEATH

07983

Reg. Dist. No.

232

1. PLACE OF DEATH o. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md.		c. LENGTH OF STAY IN 1b 1008 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1/2 Salisbury, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 112 Evans Place	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Samuel		First Middle Lost Hymn		4. DATE OF DEATH Month July Day 8 Year 1957	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH August 10, 1883		9. AGE (In years last birthday) 77 2/3 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Eastern Shore, Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-20-4842A		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, general					INTERVAL BETWEEN ONSET AND DEATH 2 days ??
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 446X Nephrosclerosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 15	
20f. (City or town) Salisbury		20g. (County) Wicomico		20h. (State) Md.	
21. I certify that I attended the deceased from 10/4/1954 , to 7/8/1957 , that I last saw the deceased alive on 7/8/1957 , and that death occurred at 1:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 7/8/57 ACTUAL SIGNATURE Dr. Juerman M.D. PHYSICIAN'S NAME (Type) V. Juerman, M. D. Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-12-57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem	
22d. LOCATION (City, town, or county) Salisbury		22e. (State) Md.		22f. (Country) USA	
23. FUNERAL DIRECTOR'S SIGNATURE Booker M. West		ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR 11 15 105	
24b. REGISTRAR'S SIGNATURE John J. Hall		24c. (City or town) Salisbury		24d. (County) Wicomico	
24e. (State) Md.		24f. (Country) USA		24g. (Date) 7/8/57	

100 15 1957

RECEIVED

07976

CERTIFICATE OF DEATH

07984
Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 300 Delaware Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma H. Jones		4. DATE OF DEATH Month 7 Day 13 Year 1957	
5. SEX F M	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 14 1871
9. AGE (In years lost birthday) yrs. 86		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Elisha Williams		14. MOTHER'S MAIDEN NAME Louise Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Louise Roberts, 300 Delaware St., Salisbury Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Regenerative Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		INTERVAL BETWEEN ONSET AND DEATH 2 months Indefinite	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 May, 1957 , to 13 July, 1957 , that I last saw the deceased alive on 13 July, 1957 , and that death occurred at 9 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 16 July 1957			
ACTUAL SIGNATURE E. A. Purnell		M.D. Salisbury, Md.	
PHYSICIAN'S NAME (Type) Dr. E. A. Purnell 652 W. Main St., Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-16-1957	22c. NAME OF CEMETERY OR CREMATORY John Wesley Cemetery	22d. LOCATION (City, town, or county) (State) Deal Island, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.		ADDRESS Salisbury, Md.	
24a. REC'D BY REGISTRAR JUL 19 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		DATE OF DEATH	
John William		1911		1957	
RESIDENCE		PLACE OF BIRTH		CITY	
Baltimore		Maryland		Baltimore	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Teacher		Heart Disease		Natural	
DATE OF INTERMENT		PLACE OF INTERMENT		CITY	
1957		Baltimore		Baltimore	
NAME OF FUNERAL HOME		NAME OF PHYSICIAN		NAME OF MINISTER	
John William		John William		John William	
SIGNATURE OF DECEASED		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
		John William		John William	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
1957		1957		1957	

BUREAU V. 2
JUL 19 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07977

CERTIFICATE OF DEATH

07985

Reg. Dist. No.

437

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN 1b <u>5 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3Y01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>1017 Valley Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Kearney</u> Last <u>Kearney</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/1861</u>
9. AGE (In years last birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Slava Kearney</u>		14. MOTHER'S MAIDEN NAME <u>Maria Siree</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. m. <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>52</u> , to <u>July 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>57</u> , and that death occurred at <u>8:28 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Deer's Head State Hospital</u> <u>7/13/57</u>	
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 16, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 17 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. HARRIS		2. SEX Male		3. AGE 45	
4. DATE OF DEATH JUL 12 1957		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN J. J. Harris	
10. SIGNATURE OF REGISTRAR J. J. Harris		11. SIGNATURE OF WITNESSES J. J. Harris		12. SIGNATURE OF DECEASED J. J. Harris	
13. SIGNATURE OF DECEASED J. J. Harris		14. SIGNATURE OF DECEASED J. J. Harris		15. SIGNATURE OF DECEASED J. J. Harris	
16. SIGNATURE OF DECEASED J. J. Harris		17. SIGNATURE OF DECEASED J. J. Harris		18. SIGNATURE OF DECEASED J. J. Harris	
19. SIGNATURE OF DECEASED J. J. Harris		20. SIGNATURE OF DECEASED J. J. Harris		21. SIGNATURE OF DECEASED J. J. Harris	
22. SIGNATURE OF DECEASED J. J. Harris		23. SIGNATURE OF DECEASED J. J. Harris		24. SIGNATURE OF DECEASED J. J. Harris	
25. SIGNATURE OF DECEASED J. J. Harris		26. SIGNATURE OF DECEASED J. J. Harris		27. SIGNATURE OF DECEASED J. J. Harris	
28. SIGNATURE OF DECEASED J. J. Harris		29. SIGNATURE OF DECEASED J. J. Harris		30. SIGNATURE OF DECEASED J. J. Harris	
31. SIGNATURE OF DECEASED J. J. Harris		32. SIGNATURE OF DECEASED J. J. Harris		33. SIGNATURE OF DECEASED J. J. Harris	
34. SIGNATURE OF DECEASED J. J. Harris		35. SIGNATURE OF DECEASED J. J. Harris		36. SIGNATURE OF DECEASED J. J. Harris	
37. SIGNATURE OF DECEASED J. J. Harris		38. SIGNATURE OF DECEASED J. J. Harris		39. SIGNATURE OF DECEASED J. J. Harris	
40. SIGNATURE OF DECEASED J. J. Harris		41. SIGNATURE OF DECEASED J. J. Harris		42. SIGNATURE OF DECEASED J. J. Harris	
43. SIGNATURE OF DECEASED J. J. Harris		44. SIGNATURE OF DECEASED J. J. Harris		45. SIGNATURE OF DECEASED J. J. Harris	
46. SIGNATURE OF DECEASED J. J. Harris		47. SIGNATURE OF DECEASED J. J. Harris		48. SIGNATURE OF DECEASED J. J. Harris	
49. SIGNATURE OF DECEASED J. J. Harris		50. SIGNATURE OF DECEASED J. J. Harris		51. SIGNATURE OF DECEASED J. J. Harris	
52. SIGNATURE OF DECEASED J. J. Harris		53. SIGNATURE OF DECEASED J. J. Harris		54. SIGNATURE OF DECEASED J. J. Harris	
55. SIGNATURE OF DECEASED J. J. Harris		56. SIGNATURE OF DECEASED J. J. Harris		57. SIGNATURE OF DECEASED J. J. Harris	
58. SIGNATURE OF DECEASED J. J. Harris		59. SIGNATURE OF DECEASED J. J. Harris		60. SIGNATURE OF DECEASED J. J. Harris	
61. SIGNATURE OF DECEASED J. J. Harris		62. SIGNATURE OF DECEASED J. J. Harris		63. SIGNATURE OF DECEASED J. J. Harris	
64. SIGNATURE OF DECEASED J. J. Harris		65. SIGNATURE OF DECEASED J. J. Harris		66. SIGNATURE OF DECEASED J. J. Harris	
67. SIGNATURE OF DECEASED J. J. Harris		68. SIGNATURE OF DECEASED J. J. Harris		69. SIGNATURE OF DECEASED J. J. Harris	
70. SIGNATURE OF DECEASED J. J. Harris		71. SIGNATURE OF DECEASED J. J. Harris		72. SIGNATURE OF DECEASED J. J. Harris	
73. SIGNATURE OF DECEASED J. J. Harris		74. SIGNATURE OF DECEASED J. J. Harris		75. SIGNATURE OF DECEASED J. J. Harris	
76. SIGNATURE OF DECEASED J. J. Harris		77. SIGNATURE OF DECEASED J. J. Harris		78. SIGNATURE OF DECEASED J. J. Harris	
79. SIGNATURE OF DECEASED J. J. Harris		80. SIGNATURE OF DECEASED J. J. Harris		81. SIGNATURE OF DECEASED J. J. Harris	
82. SIGNATURE OF DECEASED J. J. Harris		83. SIGNATURE OF DECEASED J. J. Harris		84. SIGNATURE OF DECEASED J. J. Harris	
85. SIGNATURE OF DECEASED J. J. Harris		86. SIGNATURE OF DECEASED J. J. Harris		87. SIGNATURE OF DECEASED J. J. Harris	
88. SIGNATURE OF DECEASED J. J. Harris		89. SIGNATURE OF DECEASED J. J. Harris		90. SIGNATURE OF DECEASED J. J. Harris	
91. SIGNATURE OF DECEASED J. J. Harris		92. SIGNATURE OF DECEASED J. J. Harris		93. SIGNATURE OF DECEASED J. J. Harris	
94. SIGNATURE OF DECEASED J. J. Harris		95. SIGNATURE OF DECEASED J. J. Harris		96. SIGNATURE OF DECEASED J. J. Harris	
97. SIGNATURE OF DECEASED J. J. Harris		98. SIGNATURE OF DECEASED J. J. Harris		99. SIGNATURE OF DECEASED J. J. Harris	
100. SIGNATURE OF DECEASED J. J. Harris		101. SIGNATURE OF DECEASED J. J. Harris		102. SIGNATURE OF DECEASED J. J. Harris	

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JUL 17 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7978

CERTIFICATE OF DEATH

07986

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 6 Wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Tyaskin	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BASIL Middle E. Last LARMORE				4. DATE OF DEATH Month July Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/20/1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 8 Days 28 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY American Can Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George C.H. Larmore				14. MOTHER'S MAIDEN NAME Nettie Dickerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----				16. SOCIAL SECURITY NO. -----		17. INFORMANT Alice Larmore, Tyaskin, Maryland Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work 		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) (County) (State) 							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 7-21 , 19 57 , and that death occurred at 2 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilbur R. Ellis, Jr. M.D. Salisbury, Md				DATE SIGNED 7-21-57			
PHYSICIAN'S NAME (Type) Wilbur R. Ellis, Jr.				Medical Center, Salisbury, Md. 7/21/			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/57		22c. NAME OF CEMETERY OR CREMATORY Tyaskin Cem.		22d. LOCATION (City, town, or county) Tyaskin, Maryland (State) 57	
23. FUNERAL DIRECTOR'S SIGNATURE C.H. Messick ADDRESS Bivalve, Maryland				24a. REC'D BY REGISTRAR III DATE 26 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

1957 26 JUL

RECEIVED

07987 332

07979

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b I week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium				d. STREET ADDRESS Princess Anne 19x22			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rufus N. Middle Layfield Last Layfield				4. DATE OF DEATH Month July Day 13 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9, 1882	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min.		IF UNDER 24 HRS. Months 74 Days 74 Hours 74 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James Layfield				14. MOTHER'S MAIDEN NAME Virginia Layfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Mrs. Rufus Layfield				Address Princess Anne, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis (c) Cerebral Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 350x Carbonism (Arteriosclerotic)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month. Day. Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 18, 1957 to July 7, 1957 that I last saw the deceased alive on July 10, 1957 and that death occurred at 2:30 P.M. from the cause and on the date stated above.							
ADDRESS (Street, city or town, state) Salisbury Md. DATE SIGNED July 13, 1957							
ACTUAL SIGNATURE David J. Gilmore M.D.							
PHYSICIAN'S NAME (Type) David J. Gilmore							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-17-57			
22c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian				22d. LOCATION (City, town, or county) (State) Princess Anne, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Turner R. Watson				ADDRESS Princess Anne, Md.			
24a. REC'D BY REGISTRAR July 18 1957				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of birth	
7. Cause of death		8. Duration of illness		9. Place of death	
10. Signature of physician		11. Signature of registrar		12. Signature of informant	
13. Name of informant		14. Address of informant		15. Telephone number	
16. Name of funeral home		17. Address of funeral home		18. Telephone number	
19. Name of cemetery		20. Address of cemetery		21. Telephone number	
22. Name of undertaker		23. Address of undertaker		24. Telephone number	
25. Name of mortician		26. Address of mortician		27. Telephone number	
28. Name of embalmer		29. Address of embalmer		30. Telephone number	
31. Name of funeral director		32. Address of funeral director		33. Telephone number	
34. Name of funeral home		35. Address of funeral home		36. Telephone number	
37. Name of cemetery		38. Address of cemetery		39. Telephone number	
40. Name of undertaker		41. Address of undertaker		42. Telephone number	
43. Name of mortician		44. Address of mortician		45. Telephone number	
46. Name of embalmer		47. Address of embalmer		48. Telephone number	
49. Name of funeral director		50. Address of funeral director		51. Telephone number	
52. Name of funeral home		53. Address of funeral home		54. Telephone number	
55. Name of cemetery		56. Address of cemetery		57. Telephone number	
58. Name of undertaker		59. Address of undertaker		60. Telephone number	
61. Name of mortician		62. Address of mortician		63. Telephone number	
64. Name of embalmer		65. Address of embalmer		66. Telephone number	
67. Name of funeral director		68. Address of funeral director		69. Telephone number	
70. Name of funeral home		71. Address of funeral home		72. Telephone number	
73. Name of cemetery		74. Address of cemetery		75. Telephone number	
76. Name of undertaker		77. Address of undertaker		78. Telephone number	
79. Name of mortician		80. Address of mortician		81. Telephone number	
82. Name of embalmer		83. Address of embalmer		84. Telephone number	
85. Name of funeral director		86. Address of funeral director		87. Telephone number	
88. Name of funeral home		89. Address of funeral home		90. Telephone number	
91. Name of cemetery		92. Address of cemetery		93. Telephone number	
94. Name of undertaker		95. Address of undertaker		96. Telephone number	
97. Name of mortician		98. Address of mortician		99. Telephone number	
100. Name of embalmer		101. Address of embalmer		102. Telephone number	

BUREAU V. 8

JUL 18 1957

RECEIVED

Princess Anne, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07988

07980

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				d. STREET ADDRESS <u>R. F. D. # 3</u>			
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>Lindsey</u> Last <u>Lindsey</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 20, 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>Chestertown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Broadway</u>		14. MOTHER'S MAIDEN NAME <u>Laura Graves</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent cerebral hemorrhage with left hemiplegia</u> DUE TO (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease, decompensated</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour <u>a. 11.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u> p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Salisbury, Maryland</u>		20g. (County) <u>Salisbury</u>	
20h. (State) <u>Maryland</u>		21. I certify that I attended the deceased from <u>6/28/1954</u> , to <u>7/16/1957</u> , that I last saw the deceased alive on <u>7/15/1957</u> , and that death occurred at <u>2:15 A.M.</u> , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>		23. DATE SIGNED <u>7/16/57</u>	
ACTUAL SIGNATURE <u>V. J. Guerman</u>		PHYSICIAN'S NAME (Type) <u>V. J. Guerman, M. D.</u>		24a. REC'D BY REGISTRAR <u>18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary A. Holloway</u>	
25. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		25b. DATE THEREOF <u>7-20-57</u>		25c. NAME OF CEMETERY OR CREMATORY <u>Janes Cem.</u>		25d. LOCATION (City, town, or county) (State) <u>Chestertown, Maryland</u>	
26. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Wally</u>		26b. ADDRESS <u>Chestertown, Md.</u>		26c. REC'D BY REGISTRAR <u>18 1957</u>		26d. REGISTRAR'S SIGNATURE <u>Mary A. Holloway</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. AGE 45		4. DATE OF DEATH JUL 15 1957		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH HOME		7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN DR. J. J. BROWN		10. SIGNATURE OF REGISTRAR JOHN J. BROWN	
11. PLACE OF BIRTH BOSTON, MASS.		12. OCCUPATION CLERK		13. MARITAL STATUS MARRIED		14. EDUCATION HIGH SCHOOL		15. RELIGION CATHOLIC		16. PREVIOUS ILLNESS NO		17. PREVIOUS SURGERY NO		18. PREVIOUS TRAUMA NO		19. PREVIOUS DRUGS NO		20. PREVIOUS ALCOHOL NO	
21. SIGNATURE OF DECEASED JOHN J. BROWN		22. SIGNATURE OF WITNESS JOHN J. BROWN		23. SIGNATURE OF WITNESS JOHN J. BROWN		24. SIGNATURE OF WITNESS JOHN J. BROWN		25. SIGNATURE OF WITNESS JOHN J. BROWN		26. SIGNATURE OF WITNESS JOHN J. BROWN		27. SIGNATURE OF WITNESS JOHN J. BROWN		28. SIGNATURE OF WITNESS JOHN J. BROWN		29. SIGNATURE OF WITNESS JOHN J. BROWN		30. SIGNATURE OF WITNESS JOHN J. BROWN	

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JUL 18 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7981

CERTIFICATE OF DEATH

07989

Reg. Dist. No. 232

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Pomfret 08x02			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Eulalia Lloyd				4. DATE OF DEATH Month Day Year July 10 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22, 1879	
9. AGE (In years, last birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME David K. Davis				14. MOTHER'S MAIDEN NAME Elizabeth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Hospital records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old CVA							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 8, 1957 , to July 10, 1957 , that I last saw the deceased alive on July 10, 1957 , and that death occurred at 1 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE L. V. Maldve				ADDRESS (Street, city or town, state) Deer's Head State Hospital			
DATE SIGNED 7/10/57							
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13 1957		22c. NAME OF CEMETERY OR CREMATORY Monomahela Cemetery		22d. LOCATION (City, town, or county) (State) Braddock Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home				ADDRESS Waldorf Md		24a. REC'D BY REGISTRAR DATE 15 1957	
24b. REGISTRAR'S SIGNATURE Mary H Holloway							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar. Prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

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JUL 15 1957

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The better copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07990

Reg. Dist. No. 332

C7982

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Wicomico	MARYLAND	STATE Maryland	COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 123 West Locust St		STREET ADDRESS (If rural give location) 123 West Locust St	
3. NAME OF DECEASED (First) (Middle) (Last) PURNELL CORNELIUS MADDOX		4. DATE OF DEATH (Month) (Day) (Year) July 4 th 19 57	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 20, 1871
9. AGE last birthday 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auctioneer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wicomico County Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph M. Maddox		14. MOTHER'S MAIDEN NAME Sarah Martha Shockley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.	
17. INFORMANT'S ADDRESS Mrs. Cassie M. Maddox (Wife) 123 West Locust St. Salisbury, Maryland			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420-1 IMMEDIATE CAUSE (A) Cardiac arrest			
ANTECEDENT CAUSE(S) DUE TO (B) Senility			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Coronary Thrombosis			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21a. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10/4, 1954, to July 4, 1957, that I last saw the deceased alive on 7/1, 1957, and that death occurred at 3:45 AM, from the causes and on the date stated above.			
SIGNATURE Dr. Andrew C. Mitchell		DATE SIGNED	
M.D. Maryland Ave. Office-Salisbury, Md. July 5 1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 6, 1957	
NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE JUL 8 1957		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY MARYLAND	

CERTIFICATE OF DEATH

FILE NO. 10

DEATH OF DEATH

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JUL 8 1957

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JUL 8 1957

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH ONE IN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07991

Reg. Dist. No.

CERTIFICATE OF DEATH

Items 8, 9: 6218 7/30/57 L

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Trumbull</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Warren 72x-5</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>438 Waverly Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jane</u> Middle <u>(Gery)</u> Last <u>MARIS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1893</u>	
9. AGE (In years last birthday) <u>64</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Chios Greece</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>				13. FATHER'S NAME <u>Kon Falas</u>			
14. MOTHER'S MAIDEN NAME <u>d/o Record</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mr. Theodore A. Maris (Son)</u> Address <u>438 Waverly Ave. Warren, Ohio</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 10</u> , 1957, to <u>July 10</u> , 1957, that I last saw the deceased alive on <u>July 10</u> , 1957, and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Wilber R. Ellis Jr.</u> M.D. <u>Medical Center Salisbury, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis Jr.</u> <u>July 11, 1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 14, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Weirton, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR <u>Jul 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Holloway</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

SEE PAGE 12

<p>NAME OF DECEASED [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>AGE [Faint text]</p>		<p>SEX [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>DATE OF BIRTH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>DATE OF DEATH [Faint text]</p>		<p>TIME OF DEATH [Faint text]</p>	
<p>NAME OF PHYSICIAN [Faint text]</p>		<p>NAME OF CORONER [Faint text]</p>	
<p>NAME OF FUNERAL HOME [Faint text]</p>		<p>NAME OF BURIAL PLACE [Faint text]</p>	
<p>NAME OF NEXT OF KIN [Faint text]</p>		<p>NAME OF WITNESS [Faint text]</p>	
<p>NAME OF DECEASED [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>AGE [Faint text]</p>		<p>SEX [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>DATE OF BIRTH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>DATE OF DEATH [Faint text]</p>		<p>TIME OF DEATH [Faint text]</p>	
<p>NAME OF PHYSICIAN [Faint text]</p>		<p>NAME OF CORONER [Faint text]</p>	
<p>NAME OF FUNERAL HOME [Faint text]</p>		<p>NAME OF BURIAL PLACE [Faint text]</p>	
<p>NAME OF NEXT OF KIN [Faint text]</p>		<p>NAME OF WITNESS [Faint text]</p>	

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JUL 15 1957

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CERTIFICATE OF DEATH

07992 337

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>XXX Virginia</u> b. COUNTY <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ONANCOCK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Spring Hill Private Sanitarium</u>		d. STREET ADDRESS <u>Kerr</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE</u> <u>MILLS</u>		4. DATE OF DEATH Month Day Year <u>JULY</u> <u>8TH</u> <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE (In years last birthday) yrs. <u>75</u>
11. BIRTHPLACE (State or foreign country) <u>Toronto, Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Francis Sibbold</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. C. M. Newman</u>	
17. INFORMANT <u>Mrs. C. M. Newman</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral stroke</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>444X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/7</u> , 19 <u>57</u> to <u>7-8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/8</u> , 19 <u>57</u> , and that death occurred at <u>1:23 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Dr. William Smith</u>		M.D. <u>Medical Center Salisbury, Md</u>	
PHYSICIAN'S NAME (Type) <u>Wm B Smith</u>		<u>Med. Center</u> <u>July 9 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-10-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ONANCOCK</u>	22d. LOCATION (City, town, or county) (State) <u>ONANCOCK Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carlisle M. Williams</u>		24a. REC'D BY REGISTRAR DATE <u>11 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Mary H. Talley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and Signature. The form is mostly blank with some faint, illegible handwriting.

BUREAU V. 3

JUL 11 1957

RECEIVED

CHARGE

CHARGE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17985

CERTIFICATE OF DEATH

07993

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>SOUTH MAIN STREET</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALFRED RUSSELL MITCHELL</u>				4. DATE OF DEATH Month Day Year <u>JULY 21 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 18, 1902</u> 54 yrs.	
9. AGE (In years last birthday) <u>54</u>		10. UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN STORE</u>			
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>HARRY C MITCHELL</u>				14. MOTHER'S MAIDEN NAME <u>BELLE SHARP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>215-28-3844</u>			
17. INFORMANT <u>MRS. A. R. MITCHELL</u>				Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angioplasmic Carcinoma (metastatic) of Brain</u> (b) <u>Bronchiogenic Carcinoma, Left (?)</u> (c) <u>> 12 mos (?)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>162x</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 mos?</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/17</u> , 19 <u>57</u> , to <u>7/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/21</u> , 19 <u>57</u> , and that death occurred at <u>1045</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr</u> M.D.				ADDRESS (Street, city or town, state) <u>3215 DIV ST</u> DATE SIGNED <u>7/21/57</u>			
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR</u>				<u>Salisbury, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>JUL 23 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

BUREAU V. S.

JUL 24 1957

RECEIVED

07986

CERTIFICATE OF DEATH

07994

Reg. Dist. No.

331

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 5 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 423 Pinehurst Ave.,							
3. NAME OF DECEASED (Type or print) First Middle Last William S. Sydney Moore				4. DATE OF DEATH Month Day Year 7 21 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 22, 1871	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Banker				10b. KIND OF BUSINESS OR INDUSTRY Pres. Bank			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William S. Moore				14. MOTHER'S MAIDEN NAME Laura Griffin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. None		17. INFORMANT Address William S. Moore Jr. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on July 20, 1957 , and that death occurred at 8:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 7-21-57							
ACTUAL SIGNATURE A. C. Mitchell M.D. Salisbury, Md.							
PHYSICIAN'S NAME (Type) A. C. Mitchell							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/57		22c. NAME OF CEMETERY OR CREMATORY ST. John's Cemetery		22d. LOCATION (City, town, or county) (State) Fruitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The Hill & Johnson Co. Salisbury, Maryland Norman F. Baker				24a. REC'D BY REGISTRAR DATE 7-23-57		24b. REGISTRAR'S SIGNATURE Mary W. Hollenay	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

JUL 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07995
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CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 PARSONSBURG</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BRENDA LEE MORGAN</u>				4. DATE OF DEATH Month Day Year <u>JULY 21 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 7, 1956</u>	9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>SALISBURY MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>BENNY MORGAN</u>				14. MOTHER'S MAIDEN NAME <u>ETHEL TOOEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MR. BENNY MORGAN, PARSONSBURG MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis -</u> <u>492x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>344x</u> (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydrocephalus with Vascular anastomosis. Meningitis.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 20</u> , 19 <u>57</u> , to <u>July 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>57</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert H. Sammons</u>				M.D. <u>926 Division St</u>		DATE SIGNED <u>7/21/57</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/23/57</u>		<u>TAYLORVILLE</u>		<u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burby</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 23 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

JUL 23 1957

RECEIVED

07988

CERTIFICATE OF DEATH

07996

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD.</u> 46X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>HATCHER, ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>MORRIS</u> Middle Last				4. DATE OF DEATH <u>July</u> Month <u>21st</u> Day <u>1957</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/1/88</u>	
9. AGE (In years lost birth day) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u>			
11. BIRTHPLACE (State or foreign country) <u>USA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>EARNCK G. MORRIS</u>				14. MOTHER'S MAIDEN NAME <u>ALICE TURNER.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>221-22-0005</u>			
				17. INFORMANT Address <u>MINERVA MORRIS FRANKFORD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 days</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-18</u> , 19 <u>57</u> , to <u>7-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-21</u> , 19 <u>57</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B. Ellis Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>		22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray</u> ADDRESS <u>Frankford, Del.</u>				24a. REC'D BY REGISTRAR <u>25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>	

RECEIVED

JUL 25 1957

BUREAU V. 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. TIME OF DEATH: [illegible]
10. SIGNATURE OF DECEASED: [illegible]
11. SIGNATURE OF WITNESS: [illegible]
12. SIGNATURE OF PHYSICIAN: [illegible]
13. SIGNATURE OF CORONER: [illegible]
14. SIGNATURE OF JURY: [illegible]
15. SIGNATURE OF JUDGE: [illegible]
16. SIGNATURE OF CLERK: [illegible]
17. SIGNATURE OF REGISTRAR: [illegible]
18. SIGNATURE OF [illegible]: [illegible]
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98. SIGNATURE OF [illegible]: [illegible]
99. SIGNATURE OF [illegible]: [illegible]
100. SIGNATURE OF [illegible]: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07997

07989

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>EDEN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MORTON</u>				4. DATE OF DEATH Month Day Year <u>July 27 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1957</u>	9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>1 45</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>JAMES WILLIAM MORTON</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Hughes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 mo</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 27, 1957</u> , to <u>July 27, 1957</u> , that I last saw the deceased alive on <u>July 27, 1957</u> , and that death occurred at <u>12:57 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Herbert Sembley</u> M.D.				ADDRESS (Street, city or town, state) <u>400 E. Church St. Salisbury Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. Herbert Sembley</u>				DATE SIGNED <u>7/28/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>7-30-57</u>		<u>Peninsula General Hospital</u>		<u>SALISBURY Wicomico Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Peninsula General Hospital</u>				24a. REC'D BY REGISTRAR DATE <u>7-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

2682366XVO

CERTIFICATE OF DEATH

Reg. Form No. 1

NAME OF DECEASED <i>James V. S. ...</i>		DATE OF BIRTH <i>...</i>	
SEX <i>Male</i>		RACE <i>White</i>	
MARRIAGE <i>Married</i>		DATE OF MARRIAGE <i>...</i>	
PLACE OF BIRTH <i>...</i>		CITY OF BIRTH <i>...</i>	
DATE OF DEATH <i>...</i>		PLACE OF DEATH <i>...</i>	
CAUSE OF DEATH <i>...</i>		MANNER OF DEATH <i>...</i>	
SIGNATURE OF PHYSICIAN <i>...</i>		SIGNATURE OF REGISTRAR <i>...</i>	
DATE OF SIGNATURE <i>...</i>		DATE OF SIGNATURE <i>...</i>	

BUREAU V. S.

AUG 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07998

332

07990

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Henry</u> Last <u>Nedab</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1875</u>
9. AGE (In years lost birthday) yrs. <u>82</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hezekiah Nedab</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Creek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Arteriosclerosis, general</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u> <u> </u> <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>177XCa. of prostate gland with metastases</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u> </u> Day <u> </u> Year <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>7/11/</u> , 19 <u>57</u> , to <u>7/12/57</u> , 19 <u> </u> , that I last saw the deceased alive on <u>7/12/</u> , 19 <u>57</u> , and that death occurred at <u>10:17AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>	
DATE SIGNED <u>7/12/57</u>		M.D. <u> </u>	
PHYSICIAN'S NAME (Type) <u>V. Juerman</u>		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7-12-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury City Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>V. Juerman</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	
DATE <u>7/18/57</u>		DATE <u> </u>	

BUREAU V. S.

JUL 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07991

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07999

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> <u>2342.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Box 42</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>A.</u> Middle <u>Northcutt</u> Last	4. DATE OF DEATH <u>7-24-57</u> Month <u>7</u> Day <u>24</u> Year <u>19</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1925</u> 9. AGE (In years last birthday) <u>32</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>	11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James A. Northcutt</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>256-28-8201</u>	
17. INFORMANT <u>Mrs Pauline Northcutt, Pocomoke, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compression fracture C-5</u> 902.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severed cervical cord</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Dove into 2 1/2 ft. of water and struck head on sand bar.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7-21-57</u> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Merrills Beach</u>	20f. (City or town) <u>Pocomoke</u> (County) <u>Worcester</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-25-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 30, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bascom Cemetery</u>	22d. LOCATION (City, town, or county) <u>Hilltonia, Georgia</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		24a. REC'D BY REGISTRAR <u>Mary H. Holloway</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	
ADDRESS <u>Pocomoke, Md.</u>		DATE <u>JUL 29</u>	

RECEIVED

JUL 29 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07992 CERTIFICATE OF DEATH

08000

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 11 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hosp				d. STREET ADDRESS General Delivery		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Luther Last Nutter		4. DATE OF DEATH Month 7 Day 23 Year 19 57					
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1907	9. AGE (In years lost birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Resturant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel H. Nutter				14. MOTHER'S MAIDEN NAME Annie Horner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-16-6927		17. INFORMANT Address Mrs. Evelyn Nutter, Nanticoke, Md.			
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal Cirrhosis of the Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 518 Gastrointestinal Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1957 to July 23, 1957 , that I last saw the deceased alive on July 23, 1957 , and that death occurred at M from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Schure M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Salisbury Md. July 26, 1957			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-27-57		22c. NAME OF CEMETERY OR CREMATORY Nanticoke Cemetery		22d. LOCATION (City, town, or county) (State) Nanticoke, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md				ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE JUL 31 1957 Mary T. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

RECEIVED

JUL 31 1957

BUREAU V. S.

BUREAU V. S.

JUL 31 1957

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate has been detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07993

CERTIFICATE OF DEATH

08001

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS 104 Wade St.		(If rural give location)	
3. NAME OF DECEASED (Type or Print) SALLIE (First) POPE (Middle) (Last)				4. DATE OF DEATH (Month) JULY (Day) 7th (Year) 19 57			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH August 31, 1870	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Irving Hitch				14. MOTHER'S MAIDEN NAME Sarah Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Minnie Muir (Daughter) 104 Wade St. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332x IMMEDIATE CAUSE (A) Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 7 days			
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION July 7, 1957		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1, 1957 , to July 7, 1957 , that I last saw the deceased alive on July 7, 1957 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. William Gray				ADDRESS (Street, city, town, state) M.D. Camden Ave. Salisbury, Maryland		DATE SIGNED July 1957	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 10, 1957		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY - SALISBURY, MARYLAND			
DATE JUL 11 1957							

CERTIFICATE OF DEATH

1903

LOCAL RESIDENCE OF DECEASED

Baltimore, Maryland

MARYLAND

1000000

8-11-1903

1000000

104 W. 6th St.

1000000

1903

1000000

38

August 11, 1903

1000000

1000000

Deceased at home

John

1000000

Deceased at home

1000000

Deceased at home

IN MEDICAL INVESTIGATION

BUREAU V. S.

JUL 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07994
CERTIFICATE OF DEATH

08002
Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u> <u>Route #2</u>			
d. STREET ADDRESS <u>23X02</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>R.</u> Last <u>POWELL</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 1 - 1894</u>	
9. AGE (In years, last birthday) <u>63 11/21</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>Nathaniel Pusey</u>				14. MOTHER'S MAIDEN NAME <u>Annie Cannon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Gone</u>			
17. INFORMANT <u>Ms Annie R. Street</u>				Address <u>1304 216 Clementon N.J.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1304 216</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 22, 1957</u> to <u>July 22, 1957</u> that I last saw the deceased alive on <u>July 22, 1957</u> and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Silvers</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>July 22, 1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christian Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill</u> <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay C. Dennis</u>				ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>							

JUL 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08003

Reg. Dist. No.

332

67995

FOR STATE
HEALTH DEPT.

M

82

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23

2

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN TB <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Bronx</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City 69x-3</u> d. STREET ADDRESS <u>210 W. 145th St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Lewis Redd</u>		4. DATE OF DEATH Month Day Year <u>7-27-1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>A, A.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/1926</u>
9. AGE (In years last birthday) <u>30</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>30</u> <u>0</u>	11. IF UNDER 24 HRS. Hours Min. <u>0</u> <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transport</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>William Redd</u>	
14. MOTHER'S MAIDEN NAME <u>Jeanette Baugham</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>James L. Perkins, 210 W. 145th St. N.Y.N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed skull</u> <u>816x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car that collided with a trailer truck.</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:30 a.m. 7-27-57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RFD # 13</u>	20f. (City or town) (County) (State) <u>Pocomoke Worcester Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>7-29-57</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-1-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frederick Douglas Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Staten Island N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. STEWART Salisbury</u>		24a. RECORD BY REGISTRAR <u>JUL 31 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>

RECEIVED

JUL 31 1957

BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07996

CERTIFICATE OF DEATH

08004

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Reg. Dist. No. Caroline admission) a. STATE Maryland b. COUNTY TERRELL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton 05x02			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium				d. STREET ADDRESS 319 S. 2nd St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FRANCIS Middle IRVING Last REYNOLDS				4. DATE OF DEATH Month JULY Day 16 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1868		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S. Rubber Employee			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Middletown, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME William Reynolds				14. MOTHER'S MAIDEN NAME Mary Rothwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. William A. Reynolds (Son) Address 45 Uclid Ave. Cleveland 3, Ohio			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-11 , 19 57 , to 7-16 , 19 57 , that I last saw the deceased alive on 7-16-57 , 19 57 , and that death occurred at 10:25P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip A. Ineley M.D.				ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 7-17-57			
PHYSICIAN'S NAME (Type) Dr. Philip A. Ineley				116 E. Main St. Salisbury, Md. July 17/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Drawer's Cemetery		22d. LOCATION (City, town, or county) (State) Near Odessa Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR 191957 24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

1954

1954

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APRIL 22, 1928		ALBANY, MISSOURI	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MAY 2, 1968		MEMPHIS, TENNESSEE		SHOOTING	
OCCUPATION		EDUCATION		MARRIAGE	
MEMBER OF ARMY		HIGH SCHOOL		MARRIED	
DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH	
MAY 2, 1968		JAMES EARL RAY		MAY 2, 1968	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MAY 2, 1968		MEMPHIS, TENNESSEE		SHOOTING	
OCCUPATION		EDUCATION		MARRIAGE	
MEMBER OF ARMY		HIGH SCHOOL		MARRIED	
DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH	
MAY 2, 1968		JAMES EARL RAY		MAY 2, 1968	

BUREAU V. 2

JUL 19 1967

RECEIVED

07997

CERTIFICATE OF DEATH

08005337
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Camden</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haddonfield</u> 67X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 Day</u>		d. STREET ADDRESS <u>454 Elm ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Clayton</u> Middle <u>J.</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 - 1872</u>
9. AGE (In years last birthday) <u>84 11/21</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>13</u> Days <u>4</u> Hours <u>11</u> Min. <u>21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD</u>	
13. FATHER'S NAME <u>Oliver J. Richardson</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Bowen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>246-07-6244</u>	
17. INFORMANT <u>Walden J. Richardson</u> Address <u>Haddonfield N.J.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> (c) <u>454 Elm ave</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>134.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/19</u> , 19 <u>57</u> , to <u>7/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/19</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>		ADDRESS (Street, city or town, state) <u>512 E. Market St. Snow Hill, Md.</u> DATE SIGNED <u>7/19/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 24/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Whalecat Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Grimes</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR <u>Wm. H. Holloway</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. H. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 22 1957

BUREAU V. 3

CHIEF INVESTIGATOR

Form with multiple sections and fields, including a header area with the title "CERTIFICATE OF DEATH" and various data entry fields. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise. The text is faint and difficult to read, but the layout suggests a standard death certificate form with fields for personal information, cause of death, and medical history.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08096

07998

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>614 Westover Circle</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1887</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Ellis</u>		14. MOTHER'S MAIDEN NAME <u>Annie Ellis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>219-25-3645A</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent cerebral thrombosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u> <u> </u> <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1 Arteriosclerotic cardiovascular disease, decompensated</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u> </u> Day <u> </u> Year <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15</u> , 19 <u>57</u> , to <u>July 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>57</u> , and that death occurred at <u>9:45A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>V. Juerman</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>		DATE SIGNED <u>7/17/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-17-57</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>Deer's Head State Hospital</u>		22d. LOCATION (City, town, or county) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks</u>		ADDRESS <u>130 Second Street</u> <u>Salisbury, Maryland</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>	
DATE <u>JUL 22 1957</u>			

RECEIVED

JUL 22 1957

BUREAU V. 2

RECEIVED		JUL 22 1957		BUREAU V. 2	
MAINTAIN STATE DEPARTMENT OF HEALTH - BUREAU OF HEALTH					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED					
2. SEX					
3. AGE					
4. DATE OF BIRTH					
5. PLACE OF BIRTH					
6. OCCUPATION					
7. CAUSE OF DEATH					
8. PLACE OF DEATH					
9. DATE OF DEATH					
10. SIGNATURE OF DECEASED					
11. SIGNATURE OF WITNESS					
12. SIGNATURE OF PHYSICIAN					
13. SIGNATURE OF CORONER					
14. SIGNATURE OF JURY					
15. SIGNATURE OF JUDGE					
16. SIGNATURE OF CLERK					
17. SIGNATURE OF NOTARY					
18. SIGNATURE OF SHERIFF					
19. SIGNATURE OF DEPUTY SHERIFF					
20. SIGNATURE OF CONSTABLE					
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91. SIGNATURE OF DEPUTY CONSTABLE					
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93. SIGNATURE OF COUNTY CLERK					
94. SIGNATURE OF STATE CLERK					
95. SIGNATURE OF FEDERAL CLERK					
96. SIGNATURE OF MARSHAL					
97. SIGNATURE OF DEPUTY MARSHAL					
98. SIGNATURE OF SHERIFF					
99. SIGNATURE OF DEPUTY SHERIFF					
100. SIGNATURE OF CONSTABLE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

08007 332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 209 N. 4th Street	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle -- Last ROSS		4. DATE OF DEATH Month July Day 30 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1887
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY House Carpenter	
11. BIRTHPLACE (State or foreign country) Denton, Maryland RFD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Ross		14. MOTHER'S MAIDEN NAME Irene Collins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Deer's Head Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO (c) Ca. of prostate gland with advanced metastases		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 449X Arteriosclerotic Cardiovascular Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 29, 1957 , to July 30, 1957 , that I last saw the deceased alive on July 30, 1957 , and that death occurred at 4:55A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Juerman		ADDRESS (Street, city or town, state) Salisbury, Maryland	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		DATE SIGNED 7/30/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 3, 1957	
22c. NAME OF CEMETERY OR CREMATORY Ross Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Near Federalsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton Son		ADDRESS Federalsburg Md.	
24a. REC'D BY REGISTRAR 8-1-57		24b. REGISTRAR'S SIGNATURE Mary W. Hollaway	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marion Middle Edna Last Roswell				4. DATE OF DEATH Month July Day 15 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1891	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Thomas Robins				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Paul Roswell, Delmar, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Coronary Thrombosis 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of Coronary Arteries DUE TO (c) Myocardial Infarction							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 30, 1957 , to July 14, 1957 , that I last saw the deceased alive on July 14 , 19 57 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 226 N. Division St. Salisbury, Md. DATE SIGNED 7/17/57							
ACTUAL SIGNATURE Carrie I. Hearn M.D.				DATE SIGNED 7/17/57			
PHYSICIAN'S NAME (Type) CARRIE I. HEARN				DATE SIGNED 7/17/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Del	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Gammal Co. - Delmar, Del.				24a. REC'D BY REGISTRAR 22 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

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JUL 22 1957

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CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown				c. LENGTH OF STAY IN 1b 59 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Russell				4. DATE OF DEATH Month July Day 4 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1897		9. AGE (In years last birthday) yrs. 59	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Tender	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bridge Tender		10b. KIND OF BUSINESS OR INDUSTRY Bridge		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ringold Russell				14. MOTHER'S MAIDEN NAME Margaret Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 239-20-4294		17. INFORMANT Address Mary Russell, Sharptown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 3, 1957 , to July 4, 1957 , that I last saw the deceased alive on July 4, 1957 , and that death occurred on July 4, 1957 at 9 a. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharptown, Md. DATE SIGNED 7/5/57 ACTUAL SIGNATURE H.S. Kuhlman M.D. PHYSICIAN'S NAME (Type) H.S. Kuhlman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-7-57		22c. NAME OF CEMETERY OR CREMATORY Riverton,		22d. LOCATION (City, town, or county) (State) Riverton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Gandy, Sharptown, Md.				24. REC'D BY REGISTRAR JUL 8 1957		24b. REGISTRAR'S SIGNATURE Mary Owens	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1957

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July 20, 1957

July 20, 1957

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220-10-1004 Mary Russell, Sharpstown, Md.

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JUL 8 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08001

CERTIFICATE OF DEATH

08010 332
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Wor</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY 23X22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GEN. GEN HOSPITAL</u>				d. STREET ADDRESS <u>DIV. ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cthel PATTEY Scott</u>				4. DATE OF DEATH Month Day Year <u>July 7 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 6, 1893</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED P.O. EMPLOYEE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V.S.P. OFFICE</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>POWELL PATTEY</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA BOSTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MRS. MILDRED CARMINE RYDAL PA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>332X</u> (c) <u>4 weeks</u> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/9/57</u> , 19 <u>57</u> , to <u>7/7/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 7</u> , 19 <u>57</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>July 11 1957</u>							
ACTUAL SIGNATURE <u>W. Scellio</u> M.D.				PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage Berlin Md</u>				24. REC'D BY REGISTRAR DATE <u>JUL 11 1957</u> REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Thomas</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. BIRTH DATE <i>1912</i>		6. BIRTH PLACE <i>West Virginia</i>	
7. DEATH DATE <i>July 11, 1957</i>		8. DEATH PLACE <i>Home</i>	
9. CAUSE OF DEATH <i>Heart Disease</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		12. SIGNATURE OF DEATH REGISTRAR <i>[Signature]</i>	
13. SIGNATURE OF WITNESS <i>[Signature]</i>		14. SIGNATURE OF DEATH REGISTRAR <i>[Signature]</i>	

BUREAU V. S.

JUL 11 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08011

Reg. Dist. No.

332

08002

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>7 1/2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> <u>20802</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>RFD 2 - Box 5</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>Scott</u> Last <u>Scott</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/18 98</u> ?		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u> </u>				14. MOTHER'S MAIDEN NAME <u> </u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0 Hypertensive arteriosclerotic heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 3</u> , 19 <u>56</u> , to <u>July 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 23</u> , 19 <u>57</u> , and that death occurred at <u>4:35 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>7/24/57</u>							
ACTUAL SIGNATURE <u>V. Juerman</u>		M.D. <u>Deer's Head State Hospital</u> <u>Salisbury, Maryland</u>					
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Camichael Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Queenstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Smith, Easton, Md.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>AUG 6 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8,9,14 Film 120 7-18-57 et
08003
CERTIFICATE OF DEATH

08012

Reg. Dist. No.

338

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 SALISBURY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium				d. STREET ADDRESS Springhill Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Virginia ELEANOR Sinnamon				4. DATE OF DEATH Month Day Year July 9 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1872 OCT. 22 1872	
9. AGE (In years lost birthday) 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BERLIN MD	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN SMITH		14. MOTHER'S MAIDEN NAME MINNIE LITTLETON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address MR WILLIAM SINNAMON, OCEAN CITY, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonitis 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis, Pulmonary Emphysema, Pulmonary				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 502.0				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 28.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-14-55 , 19 55 , to 7-9 , 19 57 , that I last saw the deceased alive on 7-8 , 19 57 , and that death occurred at 11:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Gilmore				DATE SIGNED Salisbury, Md July 9, 1957			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/57		22c. NAME OF CEMETERY OR CREMATORY MT. MORIAH		22d. LOCATION (City, town, or county) (State) PHILADELPHIA PA.	
23. FUNERAL DIRECTOR'S SIGNATURE Emma H. Burbage				24a. REC'D BY REGISTRAR DATE 11 1957			
ADDRESS Berlin Md				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

BUREAU V. S.

11 1957

RECEIVED

08004

CERTIFICATE OF DEATH

Reg. Dist. No.

08013327

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 4 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 Lincoln Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First ANN Middle SMITH Last		4. DATE OF DEATH July 25 19 57		Month July Day 25 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/1874		9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 9 Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Smith				14. MOTHER'S MAIDEN NAME Rebecca			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Paul Smith, 507 Lincoln Ave., Salisbury Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 24th , 19 57 , to July 24th , 19 57 , that I last saw the deceased alive on July 24th , 19 57 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hebron, Maryland DATE SIGNED 7/26/57							
ACTUAL SIGNATURE William Emrich M.D.		DATE SIGNED 7/26/57					
PHYSICIAN'S NAME (Type) William Emrich		ADDRESS Hebron, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/57		22c. NAME OF CEMETERY OR CREMATORY Hebron Cem.		22d. LOCATION (City, town, or county) (State) Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. L. Mesnick ADDRESS Bivalve, Maryland				24a. REC'D BY REGISTRAR AUG 6 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08026

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08014 327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Willards		c. LENGTH OF STAY IN lb X / Willards (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.#		d. STREET ADDRESS / R.D.#	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SADIE Middle MAE Last SMITH		4. DATE OF DEATH Month JULY Day 24th Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1911
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 2 Days 21	IF UNDER 24 HRS. Hours 2 Min. 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) R.D.# Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Marion Reddish		14. MOTHER'S MAIDEN NAME Sarah Ann Causey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. Clarence E. Reddish (Brother)	
17. INFORMANT Mr. Clarence E. Reddish (Brother)		Address Willards Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon-monoxide poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden. DUE TO (c) Sudden.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Garden hose attached to exhaust running in window of a car.	
20c. TIME OF INJURY Month, Day, Year Hour 2:20 a. m. P.M. 7-24-57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Willards Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 26 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1957	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Gardens		22d. LOCATION (City, town, or county) (State) Near Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR JUL 29 1957	
ADDRESS HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24b. REGISTRAR'S SIGNATURE Mary Holloway	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and personal information. The text is mostly illegible due to the quality of the scan.

RECEIVED
JUL 29 1957
BUREAU V. S.

08015 332

08027

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Elwood Middle SS. Last Somers				4. DATE OF DEATH Month July Day 19 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/1872		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 5 Days 17 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Ship Carpenter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Somers				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----		17. INFORMANT Nellie Hopkins, Mount Vernon, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 9. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Aug., 1947 , to 19 July, 1957 , that I last saw the deceased alive on 19 July, 1957 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard H. Saunders M.D.				ADDRESS (Street, city or town, state) Nanticoke Md.		DATE SIGNED 7/20/57	
PHYSICIAN'S NAME (Type) Richard H. Saunders				Nanticoke, Maryland 7/20/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/57		22c. NAME OF CEMETERY OR CREMATORY Turner's Cem.		22d. LOCATION (City, town, or county) (State) Nanticoke, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Messitt				ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR 26 1957 24b. REGISTRAR'S SIGNATURE Mary K. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. A.

JUL 26 1957

RECEIVED

08016

08905

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 Mardela			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS Rt. # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Bessie		Middle Sharletta		Last Stanley	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month July Day 11 Year 19 57	
9. AGE (In years last birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Bridgeville, Del.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Fisher		14. MOTHER'S MAIDEN NAME Alberta Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-5177		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inoperable Ca. of cervix uteri with generalized metastases. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH ?		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 7/2/1957 , to 7/11/1957 , that I last saw the deceased alive on 7/11/1957 , and that death occurred at 8:50 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE V. J. Nerman		M.D. V. J. Nerman, M. D.		ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED 7/12/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery		22d. LOCATION (City, town, or county) (State) Near Sharptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son,		ADDRESS Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE 7-15-57		24b. REGISTRAR'S SIGNATURE Marshall H. Nelson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar		13. Date of registration		14. Place of registration	
John Doe		Male		White		1900		New York		New York		1957		New York		Heart Disease		Natural		John Doe		John Doe		1957		New York	
15. Name of informant		16. Relationship		17. Address		18. Telephone		19. Signature of informant		20. Date of completion		21. Place of completion		22. Signature of registrar		23. Date of registration		24. Place of registration		25. Signature of registrar		26. Date of registration		27. Place of registration		28. Signature of registrar	
John Doe		Son		123 Main St		123-4567		John Doe		1957		New York		John Doe		1957		New York		John Doe		1957		New York		John Doe	

RECEIVED
 JUL 16 1957
 BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08906

CERTIFICATE OF DEATH

0801737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 1 304 E. Vine St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARGIE Middle SMITH Last SULLIVAN				4. DATE OF DEATH Month JULY Day 13 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1893		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Shad Point, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David Fields				14. MOTHER'S MAIDEN NAME Alverta Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. George E. Sullivan Jr. (Son) Address 304 E. Vine St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete heart block 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1 Congestive heart failure							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 57 , to 7/12 , 19 57 , that I last saw the deceased alive on 7/12 , 19 57 , and that death occurred at 7:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland Ave. Salisbury, Md. DATE SIGNED 7/15/57 ACTUAL SIGNATURE Dr. Earl Beardsley M.D. 7/15/57 PHYSICIAN'S NAME (Type) Dr. Earl Beardsley Maryland Ave. Salisbury, Md. July 15/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JUL 17 1957 24b. REGISTRAR'S SIGNATURE Mary H. H. Cloway			

1957 21 70

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08018337

08007

1. PLACE OF DEATH a. COUNTY Wicomico Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deers Head State Hospt.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. STREET ADDRESS 104 Chestnut St. (West)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Thomas Middle Beachamp Last Taylor				4. DATE OF DEATH Month July Day 31 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1891	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 8 Days 3		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer-Plaster (Retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Mardela, Maryland		11. BIRTHPLACE (State or foreign country) U S A			

13. FATHER'S NAME George W. Steele Taylor	14. MOTHER'S MAIDEN NAME Nettie Wingate
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Virginia D. Lee (Daughter) #10 Benjamin Ave Salisbury, Maryland
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 902.7 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hours
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1 Fractured right hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from bed and fractured right hip.	
20c. TIME OF INJURY Month, Day, Year 7-20-57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital
20f. (City or town) Salisbury		(County) Wicomico
(State) Md.		

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
DATE SIGNED 8-1-57	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 3, 1957	22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery	22d. LOCATION (City, town, or county) Mardela, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co. Salisbury, Maryland.	24a. REC'D BY REGISTRAR DATE AUG 5 1957
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MINNESOTA STATE DEPARTMENT OF HEALTH - BANGOR, MN
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 5 1957
BUREAU V. 1

08008

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAUD</u> Middle <u>LATTA</u> Last <u>TODD</u>				4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23, 1885</u>		9. AGE (In years lost birthday) yrs. <u>72</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James D. Latta</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Spann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. S. Houston Todd, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>578x</u> DUE TO <u>Ruptured Diverticulum (colon)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>443x</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Heart Disease; Chronic Bronchitis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>"</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 28, 1957</u> , to <u>July 12, 1957</u> , that I last saw the deceased alive on <u>July 12, 1957</u> , and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D. <u>Salisbury, Maryland</u>				DATE SIGNED <u>7/13/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. David J. Gilmore, Medical Center, Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The Hill & Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>7-16-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08020 337

08009

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital				d. STREET ADDRESS R.D. # 2 (Spring Hill Rd)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle ELTON Last TOWNSEND				4. DATE OF DEATH Month JULY Day 11 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 7, 1937		9. AGE (In years last birthday) 19 yrs.	IF UNDER 1 YEAR Months 8 Days 4	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Employee)		10b. KIND OF BUSINESS OR INDUSTRY A. & P. Store		11. BIRTHPLACE (State or foreign country) Salisbury, Md. Pen. Gen. Hosp.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Gilbert R. Townsend				14. MOTHER'S MAIDEN NAME Sallie Friscilla Darby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Address Mrs. Sallie P. Townsend (Mother) R.D. # 2 Spring Hill Road - Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aorta and ruptured diaphragm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 hours.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in a car that overturned.					
20c. TIME OF INJURY Month, Day, Year Hour 12:10 a. m. 7-11-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				DATE SIGNED July 12 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Memorial Gardens - Near Hebron, Maryland		22d. LOCATION (City, town, or county) (State) Salisbury Wicomico Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR JUL 15 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

RECEIVED
JUL 15 1957
BUREAU V. 1

08910 **CERTIFICATE OF DEATH**

08021

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		Wicomico		STATE		Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		SALISBURY		COUNTY		Wicomico	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Pen. Gen. Hospital		CITY OR TOWN		SALISBURY	
				STREET ADDRESS		606 Light St.	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
ANNIE RUTH TRUITT				JULY 4 th 19 57			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
Female	White	Single	Oct. 6, 1905	51			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None		None		Pittsville, Maryland		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Hiram James Truitt				Martha Emma Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Mr. Charles J. Truitt (Brother) Pemberton Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
581-0 IMMEDIATE CAUSE (A) <u>Portul Anthrax</u>						ye -	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7-3-57		Portul Anthrax					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-29, 1957, to 7-4, 1957, that I last saw the deceased alive on 7-4, 1957, and that death occurred at 6:35 A.M. from the causes and on the date stated above.							
SIGNATURE Dr. Earl L. Royer				ADDRESS (Street, city, town, state)		DATE SIGNED	
				M.D. Camden Ave. Salisbury, Maryland		July 5 / 57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial-		July 7, 1957		Pittsville Cemetery		Pittsville, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
JUL 8 1957		Nancy K. Holloway		HOLLOWAY & COMPANY		SALISBURY, MARYLAND	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bolus copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

8-1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08011

CERTIFICATE OF DEATH

08022

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Bivalve	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Troy Middle T. Last Vickers				4. DATE OF DEATH Month July Day 21 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/1890		9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months 6 Days 2	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Allen, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles C. Vickers				14. MOTHER'S MAIDEN NAME Heath			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, decompensated DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 350x Parkinson Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 18 , 19 57 , to July 21 , 19 57 , that I last saw the deceased alive on July 21 , 19 57 , and that death occurred at 7:45P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Kosmahly				M.D. Deer's Head State Hospital		DATE SIGNED 7/22/57	
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				Address Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/57		22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem		22d. LOCATION (City, town, or county) (State) Jesterville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Messers				ADDRESS Bivalve, Maryland		24a. REC'D BY REGISTRAR JUL 26 1957	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

JUL 26 1957

RECEIVED

08012

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
c. LENGTH OF STAY IN 1b 1 Hr.				d. STREET ADDRESS 436 Monticello Ave.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HOWARD Last WALLER			4. DATE OF DEATH Month 7 Day 26 Year 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1884	9. AGE (In years last birthday) 73 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Building		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Building			10b. KIND OF BUSINESS OR INDUSTRY Contractor			11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Benjamin Franklin Waller				14. MOTHER'S MAIDEN NAME Fannie Wingate			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-10-3994			
17. INFORMANT Mrs. Florence Ellis Waller, Same				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion (c) Coronary Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 year +							
INTERVAL BETWEEN ONSET AND DEATH 7 days.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 19, 1957 , to July 26, 1957 , that I last saw the deceased alive on July 26, 1957 , and that death occurred at 11:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas C. Hill Jr. M.D.				ADDRESS (Street, city or town, state) 224 N. Division St. Salisbury, Md.			
DATE SIGNED 7/26/57							
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/57		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Norman D. Baker				ADDRESS The Hill & Johnson Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR 9-22-57	
				24b. REGISTRAR'S SIGNATURE Marjory W. Holloman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUL 30 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>#317 Fairmount Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WATERS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7th</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7th 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>1</u> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ERROR</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Elizabeth Waters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Lewis James Waters - uncle</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PLACENTAL ABRUPTION</u> 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASPIRATION OF BLOOD</u> DUE TO (c) <u>ANEMIOIC FLUID</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min's</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-7</u> , 19 <u>57</u> , to <u>7-7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-7</u> , 19 <u>57</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Krone, Jr.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>William Krone, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Boggs Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>St. Lukes, Son. Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis James Waters</u>		24a. REC'D BY REGISTRAR DATE <u>7-18-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary W. Holladay</u>

5000VVVVVV

CERTIFICATE OF DEATH

1957

Funeral Home
1110 N. E. St.
Baltimore, Md.

Colored

John Elgin White
John Elgin White - White

~~*John Elgin White*~~
John Elgin White

BUREAU V. S.

JUL 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1808025
Item 9 FilmG218 8-5-57 et
08014
CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> <u>MD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Salisbury</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>20 yr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>G. B. Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>White</u> Last <u>White</u>				4. DATE OF DEATH July 25 1957			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-10</u> AGE (In years, months, days) <u>46</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>231-079234</u>		17. INFORMANT <u>Jarvis White</u> Address <u>?</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>Acute pulmonary edema.</u> DUE TO (b) <u>Left ventricular failure</u> DUE TO (c) <u>Hypertensive C.V. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>Dr. Gilmore has attended over past 3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/25/1957</u> to <u>7/25/1957</u> , that I last saw the deceased alive on <u>7/25/1957</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>211 Maryland Ave.</u>				DATE SIGNED <u>7/29/57</u>			
PHYSICIAN'S NAME (Type) <u>O. J. BURTON</u>				<u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brown Acacia</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Borku M. Lucch</u> ADDRESS <u>?</u>				24a. REC'D BY REGISTRAR <u>AUG 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Marjorie H. Holloway</u>	

CERTIFICATE OF DEATH

RECEIVED
AUG 1 1957
BUREAU V. 3

08028

CERTIFICATE OF DEATH

08026 332
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bridge St				d. STREET ADDRESS 1 Bridge St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARION Middle WILLIAM Last WILKINSON				4. DATE OF DEATH Month JULY Day 25 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 25, 1897	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 11 Days 0		IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman - Seaford Garment Co. (Shirt Factory)				10b. KIND OF BUSINESS OR INDUSTRY Mardela, Maryland			
11. BIRTHPLACE (State or foreign country) U S A				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME William Wilkinson				14. MOTHER'S MAIDEN NAME Lillie Seabrease			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Laura T. Wilkinson (Wife)				Address Bridge St. Mardela, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelogenous Leukemia 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mos							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/1 , 19 57 , to last , 19 57 , that I last saw the deceased alive on 7/24 , 19 57 , and that death occurred at 11:00 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 100 Broad Delmar, Del DATE SIGNED 7/26/57 ACTUAL SIGNATURE Ernest Larmore M.D. PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore Delmar, Delaware July 26 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery		22d. LOCATION (City, town, or county) (State) Mardela, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR July 30 1957 REGISTRAR'S SIGNATURE Mary H. Holloway			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08027
08029 CERTIFICATE OF DEATH

Reg. Dist. No. *338*

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village				d. STREET ADDRESS In Village			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LEONARD Middle COOPER Last WILLIAMSON				4. DATE OF DEATH Month JULY Day 14 Year th 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1901		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 10 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bridgeville, Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Mitchell Williamson				14. MOTHER'S MAIDEN NAME Anne Elizabeth Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Elizabeth P. Williamson (Wife) Parsonsborg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 10 min
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , 19____, to 7/14 , 19 57 , that I last saw the deceased alive on 7/15/57 , 19____, and that death occurred at 10:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) S. Division St. Salisbury, Maryland DATE SIGNED July 16/57 ACTUAL SIGNATURE Fred R. Gramse M.D. S. Division St. Salisbury, Maryland PHYSICIAN'S NAME (Type) Dr. Fred Gramse							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsonsborg, Cemetery		22d. LOCATION (City, town, or county) (State) Parsonsborg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE JUL 18 1957 Mary H. Holloway			

BUREAU V. 1

JUL 18 1957

RECEIVED

08015

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>32 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>208 New York Ave.,</u>		d. STREET ADDRESS <u>208 New York Ave.,</u>	
3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>WIMBROW</u> Last <u>WIMBROW</u>		4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sec.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. Wimbrow</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Isabell Parsons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-05-0564</u>	
17. INFORMANT <u>Mrs. John Melson, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic cardiac vascular disease</u> DUE TO (c) <u>has been attending for 15 months</u> INTERVAL BETWEEN ONSET AND DEATH <u>Dr. GRAMSE</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/28/1957</u> , to <u>7/28/1957</u> , that I last saw the deceased alive on <u>7/28/1957</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Maryland</u> <u>7/1957</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Salisbury, Maryland</u> <u>7/1957</u>			
PHYSICIAN'S NAME (Type) <u>Dr. O.J. Burton</u> <u>211 Maryland Ave., Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/30/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>7-30-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. K.

AUG 1 1957

RECEIVED

08030

CERTIFICATE OF DEATH

08029

Reg. Dist. No.

337

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardella				c. LENGTH OF STAY IN 1b Life time			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Rt #2 Delmar, Del.			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Nancy		First Braxton		Middle Winder		Last	
4. DATE OF DEATH		Month 7		Day 25		Year 19 57	
5. SEX F. M.	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 2, 1908		9. AGE (In years lost birthday) 49 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Essex Co., Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Matthew Braxton				14. MOTHER'S MAIDEN NAME Selina Gaines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Isaac Winder, Rt#2 Delmar, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease with cerebral embolism 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 month					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332x							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/20 , 19 57 , to 7/25/57 , that I last saw the deceased alive on 7/23 , 19 57 , and that death occurred at 1 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE E. M. L. [Signature] M.D.				ADDRESS (Street, city or town, state) Delmar, Del.		DATE SIGNED 7/25/57	
PHYSICIAN'S NAME (Type) E. M. L. [Signature]				Delmar, Del.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-27-1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Nebo Cemetery		22d. LOCATION (City, town, or county) (State) Columbia, Del	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE Mary H. Hallaway			

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3-11-68

4. Left to be filled with the same idea

BUREAU V. 2

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